



MISSOURI CLAIM KIT INDEX

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PACKET INFORMATION & RESPONSIBILITIES MISSOURI

The following information is designed to assist with timely and accurate reporting, as well as for education on state forms and responsibilities within the claim process. Included in this packet is the following:

- How to file a work related injury or illness.
- State forms as well as an explanation for completion and how to process:
 - Report of Injury – Form WC-1-EDI
 - Authorization to Inspect and/or Copy Medical Records – Form WC-43-AI
 - Workers' Compensation – Form WC-106
 - First Script Prescription Program
 - Job Analysis
 - Supervisor's Incident Report
 - Wage Statement
 - Return to Work Log
 - Attending Physicians Return to Work Recommendation Record
- The responsibilities of each party involved in the claim. The information contained will assist you in understanding what each party's responsibilities include from the injured employee, client employer, PEO and insurance carrier.
- Coventry/First Script temporary prescription services ID information. This document should be provided to your injured employee at the time they report an injury and are seeking medical attention. The information contained will give pharmacists the information necessary to file the claim form with SUA and should prevent the injured employee from having to pay for the prescriptions related to the work injury. Once the claim is filed with SUA a prescription drug card will be issued to the injured worker for additional prescribed medication.
- Resources and contact information. Included in this information you will find useful internet links for state forms, Coventry Provider Network Information and key contact information for SUA, including names, department and telephone and fax numbers for staff members assigned to your account.
- Posting Notice. The law requires every employer to post and maintain in a conspicuous place or places in and about the worksite a notice stating the employer has secured workers' compensation insurance coverage.

Thank you for choosing SUA Insurance Company

MO01 08/08



HOW TO FILE A WORK INJURY OR OCCUPATIONAL DISEASE CLAIM

Workers' compensation claims can be reported in several different ways, you can:

- Complete and submit the Report of Injury (Form WC-1-EDI) via the online reporting system available at www.suainsurance.com. Email the completed form to claimsintake@suainsurance.com. **This is the preferred method of reporting an injury.**

- Complete the Report of Injury (Form WC-1-EDI) and fax to SUA at 877-782-3292.

- Complete and mail the Report of Injury (Form WC-1-EDI) to:

SUA Insurance Company
Attn: Claims Dept.
222 South Riverside Plaza, Suite 1600
Chicago, IL 60606-6001

- Call the SUA Claims office at 877-782-3291. **Please refer to the Telephone Reporting Guide for assistance.**
- By contacting your broker directly and providing the appropriate first report information.
- For injuries occurring after normal business hours, please call 877-782-2112. The after hours telephone number for reporting claims provides the opportunity to report a claim 24 hours a day 7 days a week. Loss details will be gathered to determine if an emergency exists and if an immediate field contact is indicated.
- An explanation of how to complete each form is included in this packet. Also included are commonly used forms and notices and an explanation of each form's function.

MO02 08/08



TELEPHONE REPORTING GUIDE

Employer Information

Employer Name _____
Address _____
Federal Employer Identification Number (FEIN) _____
Payroll Classification Code _____

Employee Information

Name _____
Address _____
Social Security Number _____
Nationality _____
Marital Status _____
Number of Children under 18 years _____
Date of Birth _____
Occupation when injured _____
Hours worked per day _____
Average weekly wage _____

Time and Place of Injury

Location of work site where injury occurred _____
Date of Injury _____
Date Disability Began _____
When did you or the Supervisor first know about the injury _____
Name of Supervisor _____

Cause of Injury

Machine or Equipment that Caused the injury? _____
Was safety appliance provided and in use? _____
Was injury due to failure to use a safety device? _____
Describe how the injury occurred? _____

Nature of Injury

Body Part(s) injured _____
Has the employee died _____
Probable length of disability _____
Date of return to work _____
Doctor's name, address and phone number _____

SUA03 08/08



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
 DIVISION OF WORKERS' COMPENSATION
REPORT OF INJURY

P.O. BOX 58
 JEFFERSON CITY, MO 65102-0058
 (To complete form, see attached instructions)

GENERAL	EMPLOYER (NAME, ADDRESS, INCL ZIP CODE)		CARRIER ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE	
			JURISDICTION	JURISDICTION CLAIM NUMBER		
			INSURED REPORT NUMBER			
	SIC CODE		EMPLOYER FEIN		EMPLOYERS LOCATION ADDRESS (IF DIFFERENT)	LOCATION #
				PHONE #		
CARRIER CLAIMS ADMIN	CARRIER (NAME, ADDRESS & PHONE NO.)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)		
			To			
			CHECK IF APPROPRIATE	<input type="checkbox"/> SELF INSURANCE		
CARRIER FEIN		INSURANCE POLICY NUMBER			ADMINISTRATOR FEIN	
AGENT NAME & CODE NUMBER						
EMPLOYEE	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY #	DATE HIRED	STATE OF HIRE
	ADDRESS (INCLUDE ZIP)		SEX	MARITAL STATUS		OCCUPATION JOB TITLE
			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> UNMARRIED SINGLE DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		EMPLOYMENT STATUS
	PHONE #	# OF DEPENDENTS				NCCI CLASS CODE
WAGE	RATE	PER	<input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
					DID SALARY CONTINUE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
OCCURRENCE	TIME EMPLOYEE BEGAN WORK	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
			<input type="checkbox"/> AM <input type="checkbox"/> PM			
	CONTACT NAME PHONE NUMBER		TYPE OF INJURY ILLNESS		PART OF BODY AFFECTED	
	DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE	
	<input type="checkbox"/> YES <input type="checkbox"/> NO					
	ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.					CAUSE OF INJURY CODE	
DATE RETURN TO WORK		IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
			WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
TREAT-MENT	PHYSICIAN HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT	
					<input type="checkbox"/> 0 - NO MEDICAL TREATMENT <input type="checkbox"/> 1 - MINOR: BY EMPLOYER <input type="checkbox"/> 2 - MINOR CLINIC HOSPITAL <input type="checkbox"/> 3 - EMERGENCY CASE <input type="checkbox"/> 4 - HOSPITALIZED > 24 HOURS <input type="checkbox"/> 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED	
OTHERS	WITNESS (NAME & PHONE #)					
	DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER

NOTE > This form constitutes both the original notification of injury and detailed report of injury required by §287.380, RSMo (2000) and rules applicable thereto. An injury that requires immediate first aid, which does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY > All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division **MUST** be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

Missouri Department of Labor and Industrial Relations

DIVISION OF WORKERS' COMPENSATION

This employer is operating under and subject to the provisions of the Missouri Workers' Compensation Law.



If A Work Injury Occurs . . .

Missouri law guarantees certain benefits to employees who are injured or become ill because of their jobs. An injury occurs out of and in the course of employment. An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. An injury by occupational disease is compensable only if the occupational exposure was the prevailing factor in causing both the resulting medical condition and disability. Check with your supervisor if you have any questions.

Workers' Compensation Benefits Include . . .

In addition to all other compensation paid to the employee under §287.140 RSMo, the employee is entitled to receive:

★ **Medical Care.** The employer shall provide medical care as may reasonably be required after the injury or disability to cure and relieve the employee from the effects of the injury. Medical treatment is without a deductible to the employee or dollar limit. Costs are paid directly by your employer's insurance company, so you should not receive a bill. If you do receive a bill, give it to the employer's designated representative or contact the insurer listed below.

Your employer will arrange for medical treatment and select a doctor to care for your workers' compensation injury. If you want to change doctors, you must get prior authorization from the employer.

If you go to another doctor without prior authorization, it is at your expense.

★ **Payment for Lost Wages.** If you are unable to return to any form of employment due to the injury or illness, you should receive temporary total disability (TTD) benefits that are tax-free, until the treating doctor says you are able to return to work. Payments are two-thirds of your average weekly wage, up to a maximum rate set by state law. Payments are not made for the first three days or less that your employer is open for business, unless you are unable to work more than 14 calendar days. If you do not receive a check, contact the insurer listed below. An employee is disqualified from receiving TTD during any period of time that the employee applies and receives unemployment compensation.

★ **Permanent Disability Benefits.** If the injury or illness results in a permanent disability you may be entitled to receive either permanent partial or permanent total disability benefits.

★ **Death Benefits.** If the injury results in death, benefits will be paid to surviving dependents.

In The Event Of A Work Injury . . .

Employer Must:

1. Be sure first aid is given.
2. See that the injured employee is directed to a doctor or hospital, if necessary.

Employee Must:

1. Report the injury IMMEDIATELY to your supervisor or _____
(Employer's Designated Representative)
at _____ (Phone Number).

Employees who fail to notify the employer of a work injury within thirty days may jeopardize their ability to receive workers' compensation benefits.

2. If you have questions about Workers' Compensation, your employer will supply you with additional information; or you may contact an Information Specialist at the Division of Workers' Compensation 1-800-775-COMP.

**Insurance Company,
Third Party Administrator,
Service Company, or
Designated Individual If Self-Insured**

Name _____

Address _____

Phone Number _____

(Please do not insert the Division of Workers' Compensation or its toll-free number in this section)

**If
Noncompliance
Occurs . . .**

Contact 1-800-592-6003 if you believe your employer does not:

1. Insure his/her employees with workers' compensation insurance. (Coverage is required for employers who have five or more employees, one or more if in the construction industry.)
2. Report employee injuries to the Division of Workers' Compensation.
3. Post workers' compensation notice.

★ An employer who fails to insure its liability shall be guilty of a class A misdemeanor punishable by up to one year in jail and penalty of "up to three times" the annual premium the employer would have paid, or "up to \$50,000, whichever amount is greater."

**If Fraud
Occurs . . .**

Contact 1-800-592-6003 if you suspect fraudulent action by one of the following:

1. An employee, employer, insurer, physician, attorney or others involved in making a false statement in an attempt to obtain or deny a benefit as it relates to workers compensation. The false statement must be of a material fact.
2. Misrepresentation of job classification made by an employer or an insurer.

★ Fraud is unlawful and subject to criminal prosecution by the state of Missouri.

If you have questions or need more information about Workers' Compensation benefits, contact an Information Specialist at:

**Missouri Division of Workers' Compensation
3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058**

www.dolir.mo.gov/wc

1-800-775-COMP* • TDD 1-800-735-2966

**This toll-free number is provided for employee's questions only. Section 287.126 RSMo. Other persons with questions may call 888-837-6069 for information and assistance.*

**Workplace
Safety Contact**

The Missouri Division of Labor Standards offers free safety services to Missouri employers through its Missouri Workers' Safety Program (MWSP). MWSP's main goals are to help employers reduce occupational injuries and control workers' compensation costs. The Division also certifies the safety engineering and management program that is provided to employers, upon request, by their insurance carriers.

★ Employers may contact MWSP at 573-751-3403, e-mail mwsp@dolir.mo.gov for information about workplace safety or for a registry of safety consultants and safety engineers who are certified by the Division.

★ Employees are urged to direct safety related questions to their employer's designated safety person.

The Division of Workers' Compensation does not discriminate against individuals with disabilities as mandated by P.L. 101-336, The Americans With Disabilities Act. Alternative format available upon request.

**This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 573-751-4231.
This poster must be displayed in its original size 11 x 17.**

Departamento de Labor y Relaciones Industriales de Missouri
DIVISIÓN DE COMPENSACIÓN PARA TRABAJADORES

*Este empleo está operando bajo y sujeto a las provisiones de las leyes de
'Compensación para Trabajadores de Missouri'.*



Si se lastíma en su trabajo . . .

La Ley de Missouri garantiza ciertos beneficios a los empleados que se lastiman o una enfermedad causada en los trabajos. Una lastimadura que ocurra fuera de o en el curso de trabajo. Una lastimadura por accidente es compensable solamente si el accidente fué un factor prevaeciente que causó las dos, el resultado de condición médica y la incapacidad. Una lastimadura que resulten por exponerse a condiciones o substancias perjudiciales de salud (occupational disease), es compensable solamente si al exponerse a éstas condiciones fué un factor prevaeciente que causó las dos, el resultado de condición médica y la incapacidad. Pregúntele a su supervisor si tiene algunas preguntas.

Beneficios de compensación para trabajadores incluyen . . .

- En adición de otras compensaciones pagadas al empleado dentro de 287.140 RsMo. el empleado tiene derecho de recibir:
- ★ **Tratamiento Médico.** El empleo debe de proveér atención médica razonablemente requerida después de la lastimadura o incapacidad para curar y aliviar al empleado de los efectos de la lastimadura. El tratamiento médico es sin deducir dinero del empleado o límite de dinero. Los costos son pagados directamente por la compañía de seguros de su trabajo, usted no deberá recibir la cuenta. Si usted recibe la cuenta, se la puede dar a un representante designado en su empleo, o póngase en contacto con la seguranza que está alistada más adelante.
 - ★ Su empleo debe de hacer los arreglos para su tratamiento médico y seleccionar al médico que lo va atender para su lastimadura de compensación de trabajadores. Si usted quiere cambiar de médico, tiene que tener anteriormente una autorización de su empleo.
Si usted va a ver a otro médico sin tener anteriormente una autorización de su empleo, será por su cuenta.
 - ★ **Pagos de Sueldos Perdidos.** Si usted está inhábil de regresar en cualquier forma a trabajar debido a la lastimadura o enfermedad, usted deberá recibir un pago de incapacidad total temporal (TTD) beneficios sin pagar taxes, hasta que el médico le diga cuando puede regresar a trabajar. Los pagos serán dos terceras partes de su salario semanal, hasta un máximo que está proporcionado y establecido por la ley del estado. No se le pagará por los primeros tres días o menos que el empleo está abierto, a menos que no haya podido trabajar por más de 14 días de acuerdo al calendario. Si usted no recibe su pago, póngase en contacto con la agencia de la aseguranza que está alistada más adelante. Un empleado está descalificado de recibir incapacidad total temporal (TTD) durante el periodo de tiempo en que el empleado solicita y recibe compensación de desempleo.
 - ★ **Beneficios de Desabilidad Permanente.** Si la lastimadura o la enfermedad resulta en una incapacidad permanente usted tiene derecho de recibir ya sea un parcial permanente o un total permanente en beneficios de incapacidad.
 - ★ **Beneficios de Muerte.** Si la lastimadura resulta en muerte, los beneficios serán pagados a sus dependientes.

En el evento de una lastimada en el trabajo . . .

La Compañía Debe de:

1. Asegurarse se administren los primeros auxilios.
2. Ver que el empleado accidentado sea dirigido a un doctor u hospital, si es necesario.

El Empleado Debe de:

1. Reportar el accidente INMEDIATAMENTE a su supervisor o _____
(Representante designado en su empleo)
al _____ (Número de Teléfono).

Empleados que fallen en notificar a su empleo de la lastimadura en el trabajo dentro de treinta días puede arriesgar la habilidad de recibir beneficios de compensación para trabajadores.

2. Si tiene preguntas sobre Compensación para Trabajadores, su empleo le puede dar información adicional o pedir información por medio de un especialista en la División de Compensación para Trabajadores 1-800-775-COMP.

Proveedor de aseguranza, Administración grupo de demandas (Third Party Administrator), Compañía de servicios, o La persona designada(o) asegurado por sí mismo

Nombre _____
Domicilio _____
Teléfono _____

(Por favor no insertar en ésta sección el teléfono sin costo de para la División de Compensación para Trabajadores.)

Si es que falta de cumplimiento ocurre . . .

Llamar al 1-800-592-6003 si usted creé que su empleo no le:

1. No asegura a sus empleados con seguridad de compensación para trabajadores. (Protección es requerida para los trabajos que tienen cinco o más empleados, uno o más si es en la industria de construcción.)
 2. No reporta accidentes de los empleados a la División de Compensación para Trabajadores.
 3. No pone los anuncios de compensación para trabajadores.
- ★ Un empleo que falle de sus obligaciones de asegurar será culpable de la clase A mala conducta, será castigado hasta un año en la prisión y una multa de “arriba de tres veces más” del precio anual que deberían pagar el empleo o “hasta \$50,000 cualquiera que sea más grande”.

Si fraude ocurre . . .

Llame al 1-800-592-6003 si usted sospecha que algún acto fraudulento ha ocurrido por uno de los siguientes:

1. El empleado, empleo, la seguridad, un doctor, un abogado u otras personas envueltas falsamente llenan una declaración para intentar obtener o negar beneficios relacionados con la compensación de trabajadores. La declaración falsa tiene que ser en realidad esencial.
 2. Falsear la clasificación de trabajo hecha por la compañía o seguridad.
- ★ Fraude es contra la ley y sujeto a cargos criminales prosecución por el Estado de Missouri.

Si tiene preguntas o necesita más información sobre los beneficios de Compensación para Trabajadores, póngase en contacto con un Especialista de Información a:

Missouri Division of Workers' Compensation
3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058
www.dolir.mo.gov/wc
1-800-775-COMP* • TDD 1-800-735-2966

*Este número está designado sin costo, únicamente para empleados con preguntas, Sección 287.126 RSMo.
Cualquier persona puede llamar al 888-837-6069 para recibir información y asistencia.

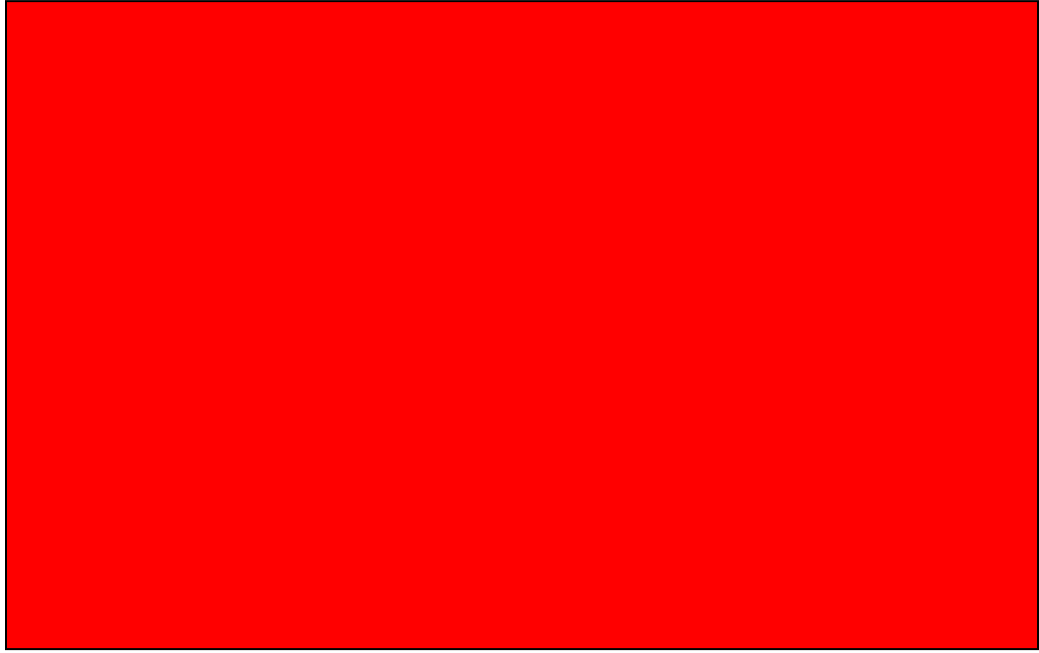
Contacto para la seguridad en el trabajo

La División de Normas de Trabajo para Trabajadores de Missouri le ofrece servicios de seguridad a los empleos de Missouri a través del Programa de Seguridad de Trabajadores en Missouri (MWSP). MWSP's las principales metas es de ayudar a los empleos en reducir accidentes relacionados con el trabajo y controlar los costos de la compensación de trabajadores. La División también certifica un programa de seguridad manejada y administradamente suministrada para los empleos, si usted la requiere, por medio de la seguridad.

- ★ Los empleos pueden ponerse en contacto con MWSP al 573-751-3403, por e-mail a mwsp@dolir.mo.gov para información acerca de la seguridad en el trabajo o para un registro de consultantes que suministran seguridad y son certificados por la División.
- ★ Los empleados deben de dirigir con urgencia sus preguntas relacionadas a la seguridad con la persona designada de su empleo.

La División de Compensación para Trabajadores no discrimina contra individuos deshabilitados en acuerdo con los mandatos de P.L.101-336, The Americans with Disabilities Act. Información alternativa está disponible si lo requiere.

Este cartelón es requerido por la Sección 287.127 RSMo y está disponible a los empleos y a las seguranzas sin costo alguno solo llamando al 573-751-4231. Este cartelón tiene que ser desplegado en su tamaño original de 11 x 17 (once por diecisiete pulgadas).





STATE FORMS MISSOURI

- ***Missouri Form WC-1-EDI: Report of Injury*** – This form is to be completed when an employee reports a work-related injury or disease. Please complete the form with as much available information as possible. This will assist in the prompt and accurate claims set up.
- ***Missouri Form WC-106: Workers' Compensation Workplace Posting***
- ***Missouri Form WC-43-AI: Authorization to Inspect and/or Copy Medical Records***



MISSOURI FIRST REPORT OF INJURY FORMS PACKET

Missouri Form WC-1-EDI: Report of Injury

MISSOURI FORM WC-106: WORKERS' COMPENSATION POSTING

MISSOURI FORM WC-43-AI: AUTHORIZATION TO INSPECT AND/OR COPY MEDICAL RECORDS

SUPERVISOR'S INCIDENT REPORT

WAGE STATEMENT

ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

JOB ANALYSIS

RETURN TO WORK LOG

MO04 08/08



SUPERVISOR'S INCIDENT REPORT

 Injury(work related)

 Incident

 Illness (work related)

Employee Name (First, MI, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			Home Telephone Number			
Employee's Street Address						City			State		Zip Code	
Age	Birth date Mo Day Yr		Job Title			Department						
Employee's Scheduled Work Week When Injured		Start time	End time	Hrs Per Day	Hrs Per Wk	Days Per Wk		Normal Full-Time Schedule for Injured's Work	Start Time	End Time		
Injury date Mo Day Yr		Hour of Day		Last Day Worked Mo Day Yr			Last Day Worked Mo Day Yr			<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		

Did employee seek medical attention? Yes No

If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will employee complete a drug screening? Yes No

Name of Witnesses Names (Attach statements if available)

1. _____ 2. _____

Injured employee's statement of what happened. (Identify circumstances and equipment involved)

How could this incident been prevented?

What corrective action has been taken?

Part of Body Affected							
<input type="checkbox"/> Eye	<input type="checkbox"/> Hip	<input type="checkbox"/> Head	<input type="checkbox"/> Foot	<input type="checkbox"/> Neck	<input type="checkbox"/> Wrist	<input type="checkbox"/> Back	<input type="checkbox"/> Hand
<input type="checkbox"/> Arm	<input type="checkbox"/> Toes	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Ankle	<input type="checkbox"/> Fingers	<input type="checkbox"/> Elbow	<input type="checkbox"/> Leg	<input type="checkbox"/> Other
Type of Injury							
<input type="checkbox"/> Cut/Abrasion	<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Foreign Object	<input type="checkbox"/> Burn	<input type="checkbox"/> Break	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Exposure	
<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Other						

Comments _____

Supervisor Signature _____

Date _____

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WAGE STATEMENT

Employer: _____

Employee: _____

Please provide the **52 weeks** of wages prior to the date of injury of _____

Date employee ceased to work: _____ Date Hired _____

Number of Hours employee is scheduled to work per week: _____ Claim Number _____

Is employee paid by hour, day, week or month _____ At what rate: _____

Does Employee work Overtime Yes No If yes, is Overtime mandatory Yes No

State the date and amount of any pay increases during the past 52 weeks

Date _____ Amount _____ Date _____ Amount _____

Date _____ Amount _____ Date _____ Amount _____

	Dates Incl of each Week Pd			Hrs Wkd	Regular Pay		Overtime Pay			Dates Incl of each Week Pd			Hrs Wkd	Regular Pay		Overtime Pay	
	From	To	Yr							From	To	Yr					
1									27								
2									28								
3									29								
4									30								
5									31								
6									32								
7									33								
8									34								
9									35								
10									36								
11									37								
12									38								
13									39								
14									40								
15									41								
16									42								
17									43								
18									44								
19									45								
20									46								
21									47								
22									48								
23									49								
24									50								
25									51								
26									52								
SUBTOTAL										SUBTOTAL							
										GRAND TOTAL							

This is a correct statement of Employee's earnings as actually taken from Payroll Records

Employer's Signature _____ Title _____ Date _____



ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

Claim No _____																											
Patients Name (First)	(Middle Initial)	(Last Name)	Date of Injury/Illness																								
TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK																											
Diagnosis/Condition (Brief Explanation)																											
I saw the and treated this patient on _____ and based on the above description of the patient's current medical problem:																											
1) <input type="checkbox"/> Recommend his/her return to work with no limitations on _____																											
2) <input type="checkbox"/> He/She may return to work on _____ capable of performing the degree of work checked below with the following restrictions:																											
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, ledgers and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met	1. In an 8 hour day patient may: a) Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 1-4 hours <input type="checkbox"/> 4-6 hours <input type="checkbox"/> 6-8 hours b) Sit <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours c) Drive <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours 2. Patient may use hand(s) for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation 3. Patient may use foot/feet for repetitive movement as in operating foot controls <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>																										
<input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls	4. Patient is able to: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 20%;">Frequently</th> <th style="width: 20%;">Occasionally</th> <th style="width: 20%;">Not at All</th> </tr> </thead> <tbody> <tr> <td>Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Twist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Reach</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>				Frequently	Occasionally	Not at All	Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.																											
<input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.																											
<input type="checkbox"/> Medium Heavy Work. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds																											
<input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds																											
Other Instructions and/or Limitations Including Prescribed Medications:																											
The restrictions are in effect until _____ or until patient is reevaluated on _____																											
3) <input type="checkbox"/> He/She is total incapacitated at this time. Patient will be re-evaluated on _____.																											
Physician's Signature		Date																									

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Hand Coordination Activities				
Movement Required	Tool/Machine	Right	Left	Both
Major hand				
Fine manipulation				
Gross manipulation				
Simple grasping				
Power grip				
Hand twisting				
Pushing				
Pulling				
Tools Used by Worker		Weight	No. of Hands Needed to Move	
Objects Worker must Move During Day		Weight	Distance	No. of Workers Needed to Move
Physical Surroundings		Does Employee Walk on Uneven Ground?		
Does Employee Work <input type="checkbox"/> Inside _____% <input type="checkbox"/> Outside _____%		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Work Around Moving Machinery?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Drive Automotive Equipment?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, describe:				
Does the Employee Come in Contact with the Following? (indicated type)	Yes	No	Type	
Fumes				
Dust				
Mist				
Steam				
Strong Odors				
Poor Ventilation				
Air Conditioning				
Characteristics of Job that cannot be Modified by Employer for this Employee				
Comments and/or Observations				
<input type="checkbox"/> Job Site Evaluation Done		<input type="checkbox"/> Narrative		
Name(s) of Person(s) Interviewed		Title		
Person Completing Analysis		Title	Date	



RETURN TO WORK LOG

Employee Name _____

Supervisor _____

Date	Hours Worked		Tasks Performed	Comment Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I understand, take responsibility for and acknowledge the _____ has placed me on limitations my physician, Dr. _____ while Participating in this temporary transitional work program.

Employee Signature _____

Date _____

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RETURN TO WORK LOG

The Return to Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps to eliminate potential conflicts should questions arise regarding your employees performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employees' restrictions to the log.
- Have employees write their name on top of the log and have the Supervisor write their name.
- Remind the employees it is their responsibility to follow the restrictions.
- Remind the employees the restrictions apply to occupational and non-occupational activities.
- Employees and Supervisors review all tasks completed each day and indicate any concerns. Initial after each day in confirmation of the review of tasks and consideration of concerns.
- Have the employees sign and date the Log at each week's end.



ROLES & RESPONSIBILITIES

Employee:

If a work place accident should take place, it is your responsibility to take the following actions, injury permitting:

- Report any injury or illness immediately to your supervisor or manager, in writing if possible. Make sure to tell the supervisor what, where, when and how the injury occurred.
- For occupational diseases, you should notify your employer as soon as practicable after you become aware of the condition.
- Failure to report your injury or occupational disease to your employer may result in a forfeiture of workers' compensation benefits. To ensure your rights to benefits, notify your employer of the injury or occupational disease in writing within 30 days.
- Seek prompt medical attention from a health care provider authorized by your employer.

Employer:

Upon notice of a work injury or occupational disease you should take the following steps:

- Inform the insurance carrier or administrator responsible for the workers' compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting.
- You should make sure your employee receives necessary medical care to treat the injury.
- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.
- To avoid delay of processing the claim it is recommended, at a minimum, the following information be provided to the insurance carrier or administrator:
 - Employee's name
 - Address
 - Telephone number
 - Social security number
 - Brief description of the injury, accident or disease
 - Authorization Release of Medical Information
 - Wage Earnings History
 - Notice of Claim Received
 - Witness statements and supervisor reports, if available.

Insurance carrier:

Once SUA receives notice of a work place injury via the agreed reporting method and the claim has been properly verified and set up, SUA will take the following steps:

- Three (3) point contact for all lost time claims, contact to the employer, employee and providers.
- SUA report injuries on a Report of Injury (Form WC-1) as well as all other required reports to the Division of Workers' Compensation.
- SUA pays medical costs incurred from the injury and makes benefit payments if work is missed due to an injury.



- Ensure a timely determination of compensability by requesting from affected parties any information needed to determine:
 - a. If a temporary or permanent disability exists relative to the employee's ability to do their job.
 - b. If the disability is caused by the employee's work.
- If the employee is off work because of the injury more than three (3) days during which the employer's business or operation is open, the employee is entitled to lost wage benefits.



SUA INSURANCE COMPANY SUBROGATION PROGRAM

SUA Insurance Company (SUA) recognizes the importance of subrogation and recovery in all lines of business it writes. SUA's dedicated team of professionals works diligently to aggressively identify subrogation, second injury fund, salvage, deductible, and any other type of recovery to mitigate the overall payout of the claim.

SUA claims are handled by experienced claim professionals skilled in all aspects of workers' compensation claims handling and subrogation.

SUA maintains full-time dedicated subrogation specialists on staff overseeing all aspects of the investigation and timely notification to all parties while ensuring our lien is protected and utilized in the most advantageous means to resolve the issue.

SUA's philosophy on recovery is multifaceted and factors in all parties involved with our claims which include the insureds, Partner Agents, claim examiners, Corporate Claim Analysts, and SUA Management.

SUA believes its multifaceted approach gives each party an opportunity to recognize opportunities to help mitigate the overall payout on claims received while also recognizing possible safety hazards that can prevent future accidents from occurring.

For additional information, please contact Ed Eisman at SUA 312-258-6822.



RESOURCES

SUA Insurance – www.suainsurance.com

Coventry Workers' Comp Services – <http://coventrywcs.com>

Missouri Department of Labor and Industrial Relations/Division of Workers' Compensation - <http://www.dolir.missouri.gov/wc/index.asp> - For General Questions 573-751-4231

Missouri Workers' Compensation Disability Benefit Information – <http://www.dolir.missouri.gov/wc/forms/101-AI.pdf>

Missouri Workers' Compensation Fraud and Noncompliance Division - <http://www.dolir.missouri.gov/wc/fraud/index.htm>

State of Missouri Revised Statute on Workplace Posters - <http://www.moga.mo.gov/statutes/C200-299/2870000127.HTM>

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